STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005092	A. BUILDING: _____ B. WING _____	05/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT WILLIAMSPORT HOSPITAL INC	412 N MONROE ST WILLIAMSPORT, IN 47993

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 005092 Type of Survey: State Licensure Off Site JCAHO Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 5/14-15/2012 Date of ISDH off site review - 9/10/2013 Reviewer/Surveyor -Nancy Otten, RN, PHNS Based on review of the May 14-15/2012 JCAHO Accreditation Survey Report, it has been determined that St. Vincent Williamsport Hospital meets the requirements for Hospital Licensure in Indiana in 2012.	S 000		